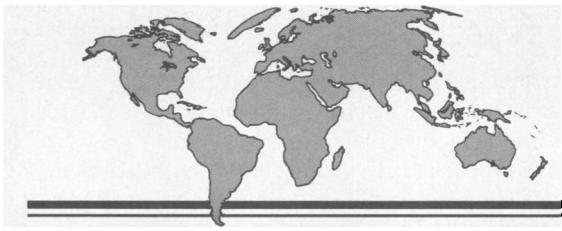

Social, Cultural and Demographic Aspects of AIDS

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Both on national and international levels, the acquired immunodeficiency syndrome (AIDS) represents a formidable challenge to social institutions and to cultural assumptions. Its effect thus far, in what must be considered the very early stages of a protracted and unprecedented epidemic, has been to exacerbate existing social tensions and divisions over a surprisingly wide field. Though international leadership by the World Health Organization has been met with an unusually high degree of multinational cooperation, AIDS has also stimulated a degree of xenophobia and racial friction that, if allowed to grow, could handicap global AIDS control and prevention efforts.

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If there is an intellectually acceptable way of characterizing the social and cultural impact that the acquired immunodeficiency syndrome (AIDS) has had in the seven years since it was first diagnosed, it may be to say that this disease has exhibited an unusual propensity to exacerbate existing tensions within the body politic. Simultaneously, AIDS has inspired some impressive feats of community and international cooperation, among them the epidemiologic detective work that first uncovered the disease; the organization of the American homosexual community to meet the crisis in its ranks; the outstanding efforts on the part of a number of the world's low and medium income countries to develop national AIDS control strategies in the face of severe resource shortages, and the creation and operation by the World Health Organization (WHO) of its Special Programme on AIDS, making it the widely acknowledged leader in the field of international AIDS prevention and control.

AIDS and Social Divisiveness

To say that AIDS accentuates social divisions may at first seem to state the obvious, but an attempt to list instances of this phenomenon soon reveals that they are both more numerous and more wide-ranging than might initially have been supposed. Erroneously perceived at first as a specifically gay disease, AIDS has triggered a homophobic backlash that at its violent worst is manifested in episodes of AIDS-related attacks ("gay bashing") such as have been reported recently in the United States, Europe, Brazil and Mexico. Gay organizations, with some supporting statistical evidence, believe that such attacks are increasing and are likely to continue to do so. Prostitutes, too, have been the object of discriminatory and sometimes violent attention. Data from serologic studies on groups of prostitutes in African countries and elsewhere have revealed high and fast-rising rates of seropositivity, with the result that these prostitutes have tended to be seen more as a source of infection with the human immunodeficiency virus (HIV) than as a group particularly vulnerable to it. They have also been seen as a source of bad publicity by governments anxious to downplay the presence of AIDS in their countries. Whether in India, Kenya or the United States, the jailing of prostitutes has more accurately reflected the contempt of society for a marginal group than sound policies for arresting the spread of HIV. At least two murders of streetwalkers in Britain are believed to have been AIDS-related revenge killings.

As infection spreads, the polarization within society between those who are carriers of the virus and those who are not will increase. In June 1987 in Washington, DC, the growing antagonism between the two camps was made audibly evident during speeches dealing with the Reagan administration's views on selective mandatory testing. The President was booed and hissed at a fundraiser; Vice President Bush and Health Secretary Bowen received the same treatment as they addressed the Third International Conference on AIDS. Whatever other effects it produces, mandatory testing defines a class of HIV-carrying people whose legal rights and social prospects are thereby jeopardized.

This is equally true in the Third World, where hints of what is in store are already emerging. African students studying abroad on scholarships have been subjected to compulsory blood tests in several countries, including Belgium, West Germany, China and India. Those found to be carrying the virus have been summarily sent home to an uncertain future. African countries may decide to initiate their own screening programs for students before they go away, to save the ignominy and expense of having them rejected abroad. A seropositive student bright enough to secure a scholarship may now have few career prospects and be tormented by uncertainty about the risk of the development of the full-blown disease.

It remains to be seen whether the growing numbers of people shown to be virus carriers through both mandatory and

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ABBREVIATIONS USED IN TEXT

AIDS = acquired immunodeficiency syndrome
HIV = human immunodeficiency virus
WHO = World Health Organization

voluntary testing schemes will be harbored humanely within their societies or increasingly victimized as plague carriers. At the present time there appears to be a precarious balance between the two reactions, but as the number of AIDS cases continues to rise inexorably (as it must—at least until the infections already contracted are fed through the epidemiologic curve), victimization seems likely to increase.

AIDS and Sexual Mores

The reevaluation of sexual mores that has been provoked by AIDS highlights another social debate, which in the West might be characterized as the argument between those who believe that sex can be made safe and those who believe that "to condom is to condone." That religion enters into this quarrel makes it all the more acrimonious; that it bears on the content of AIDS education programs for the younger generation makes it all the more acute.

The battleground in African and Asian countries may be quite different. There, sexual behaviors rooted in tribal traditions may prove to be obstacles to AIDS control in cultures where marital fidelity must be viewed outside the Judeo-Christian model of monogamy. For example, according to Zambian tradition, when a man dies his male relatives must have sex with his widow to cleanse from her the ghost of her husband. Among senior women (who can wield considerable influence) there is a strong resistance to any move to eradicate this practice. Though eradication would reduce the risk of HIV transmission, it would also, they feel, reduce the opportunity for widows to remarry and thus the material prospects of both widows and their children. To complicate matters, those who argue for changes in tradition to avert the spread of HIV may be tagged as having been "Westernized"—that is, having become alienated from their heritage as Africans and members of their tribe. Worldwide, what starts with sex ends in a complex of emotive religious and cultural issues that may take generations to untangle. Where the family (in the West) or the clan (in Africa and Asia) feels threatened as a fundamental social institution, AIDS control is likely to become more difficult.

Another sort of conflict in the field of biomedical research was dramatically illustrated by the dispute over the discovery of the AIDS virus between the rival laboratories of Robert Gallo and Luc Montagnier. Well covered in the media, the dispute became common knowledge even among segments of the public normally impervious to such issues and may have promoted a degree of cynicism about the value of scientific research in an economic climate where such research has been under fire.

A new dispute, over the potential therapeutic value of peptide T, has subsequently received substantial press coverage. The extent to which such issues may diminish public confidence in AIDS research is unclear, but their importance in this regard, particularly when two decades of investment in cancer research are now under heavy attack, should not be underestimated.

The production of an AIDS vaccine and its shepherding through all phases of clinical trials will require a high degree of public trust in the scientific community. Scientific controversies that tend to erode that trust must therefore be regarded as matters of serious concern.

AIDS is a propagandist's dream come true. Whether for a politician courting the support of an electorate tilted toward religious fundamentalism, a research scientist seeking funding for a large laboratory, a journalist looking for a big story or a parent trying to keep the children on the straight and narrow, the mention of AIDS is a trigger that generates an unusually complex array of social responses. Given the present incomplete state of knowledge about the acquired immunodeficiency syndrome—about the origins and the extent of spread of HIV, the dynamics and exact mode of its transmission, the natural history of the disease, the opportunities for therapeutic intervention and the psychological effects of infection—there exists a vast arena in which discourse on AIDS can take place free of the hazard of bumping into too many inconvenient facts. The social experience of infectious disease is founded on memories of past epidemics, and there are few, if any, historical parallels to the AIDS pandemic to which we can refer in the search for models of understanding and response. But there is a diagnostic test for exposure to HIV, and so the reflex human response to pestilence—to build a wall around the city—has become translated into the exercise of excluding presumably dangerous foreigners by screening their blood before they are allowed to enter the country. More than a dozen countries have decided to adopt such screening as a control measure, in spite of its obvious deficiencies: cost, inconvenience and failure to detect those whose exposure to the virus is very recent. The World Health Organization's advice—that screening of travelers is epidemiologically ineffective and diverts resources from measures more likely to prevent new infections—has been widely ignored.

Screening Practices

From the point of view of infection control, absurdities have resulted. One Austrian city screens foreigners requiring work permits, though nationals who may have contracted HIV in another part of Austria are not tested. Belgium screens students receiving state scholarships; are non-scholarship students considered less likely to have been exposed to the virus? Cuba screens nationals returning from AIDS-endemic regions and all foreigners except tourists—the hard currency that accompanies tourists presumably exerts a prophylactic effect with regard to the spread of HIV. Finland will soon screen all foreign students, though not its own students, who may have been exposed to the virus in the very countries from which the foreign students originate. In the West German state of Bavaria, resident foreigners, unless they come from a country that is a member of the European Community, must prove that they are HIV-negative. The fact that neighboring Belgium and France have very high numbers of AIDS cases per capita appears not to matter. India screens all foreign students and foreigners who wish to stay longer than one year except journalists. Kuwait, Saudi Arabia and the United Arab Emirates screen foreign workers, the Philippines screens long-term foreign residents and Iraq apparently screens everyone entering the country.

The United States, with more AIDS cases than have been reported from all other countries combined, will soon screen those foreigners who apply to immigrate there. Like the other politicians who enacted legislation to put screening of for-

eigners in force, President Reagan had available to him expert information that could easily have made plain the ineffectual nature of such measures in halting the global spread of AIDS. Like other politicians, he justified his decision in favor of mandatory screening as a step that was necessary to stem the advance of the disease. In doing so he, like other policy makers in favor of screening foreigners, was responding to a deeply felt social need to feel that barriers against AIDS can be erected that will make it easy to distinguish between the places where the virus is and the places where it is not. It is not surprising that people respond to a new and little understood danger by seeking a place of safety, a vantage point from which to observe and gauge the severity of the threat. What is unfortunate is that with AIDS, the sheer inappropriateness of this response is likely to provide the false sense of security that will lead to new and unnecessary HIV infections.

Placing the 'Blame'

Almost universally (and futilely) the social response to the appearance of HIV has been to try to locate the source of the epidemic in another country, culture or race. In the early stages of the American epidemic the classification of homosexuals and Haitian nationals as risk groups gave credence to this tendency. The efforts of American researchers to locate the origins of the AIDS virus in west or central Africa have lent impetus to the popular Western belief that the AIDS pandemic must have started somewhere on the "dark continent." It is no accident that African students were the first and selective targets of the mandatory screening measures that many countries have implemented. The link between AIDS and Africa now seems to be indelibly imprinted on the public mind, at least in the Western hemisphere.

You might, for example, in planning an African holiday, pick up a copy of the *1987 Fodor's Guide to Kenya.* There, as part of a generally helpful section on AIDS, you would find the statement that "Doctors speculate that in some African countries the infection rate may be 30% of the total population." There are no data to support such an assertion from any of the AIDS-affected African countries, least of all from Kenya, where at present serologic testing confined mainly to high-risk groups suggests that the current prevalence of HIV in the general population may be 1% or less. Many Africans fear that such inaccurate statements may create a climate in which tourism and other forms of commerce and exchange are blighted and in which discrimination against Africans is fueled. That African students abroad have already been victimized confirms that their fears may be well founded.

That the AIDS picture may look very different from the African or Asian perspective is a fact that Western societies have largely chosen to ignore. In a number of African countries the media have vociferously denounced Western researchers and journalists whose statements proposed Africa as the point of origin of HIV. Throughout most of Africa and Asia the common view is that the AIDS pandemic began with American homosexuals and was spread around the world by American travelers and imported American blood products. Anecdotal information illustrates this perspective. Recently, in Nairobi, a female Kenyan colleague walked down a main street with a visiting male British journalist. A friend of the Kenyan who saw them shouted out jokingly in Swahili: "Watch out—you'll get AIDS!" In the Philippines, a woman's group called Gabriella is trying to organize a lawsuit against the United States military. In their view, the 44 female prostitutes who have recently tested positive for HIV antibodies have been infected by servicemen clients from the American naval base at Subic Bay.

Anti-Western sentiment is not restricted to the person in the street. Noboru Takeshita, Japan's new prime minister, told this joke at a political fundraiser: Because of the soaring value of the Japanese yen, he said, American servicemen can no longer afford to go out with Japanese hospitality girls. Instead, they are staying on base giving AIDS to each other.

A short time ago in London, a group of two dozen experienced but nonmedical journalists from Asia, Africa and Latin America gathered for a seminar at the British Broadcasting Corporation. When they were asked informally how the AIDS pandemic got started, they responded with what they regarded as the accepted view: AIDS started in the United States and was carried to their countries mainly by Americans traveling abroad.

It is important to recognize that wherever people feel that they can assign blame for the spread of HIV to a defined cultural or racial group other than their own, they tend to feel that they have gained some measure of protection from infection. Among ethnic minority groups in New York City, for example, there has been a strong denial—despite the evidence that blacks and Latinos are currently contracting HIV at a faster rate than whites—that the disease they view as quintessentially the result of the "white man's vice" (homosexuality) could have invaded their community.

Racially or culturally based views about the transmission of HIV may in the long run be more difficult to erase and more obstructive of infection prevention than the other common type of misunderstanding—that one can "catch AIDS" through casual contact. It is much easier, on finding that the virus is among us, to blame an outsider than it is to blame a toilet seat or a beer glass. Thus, an observable impact of AIDS has been to sharpen existing social and racial divisions both within and between nations. While it has frequently been remarked that the chief cultural impact of AIDS will be the questioning of sexual mores and the more stringent social regulation of sexual behavior, AIDS has the potential of igniting intergroup enmity and conflict that may prove to be more profound.